STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE HEALTH & REHAB OF COLLIERVILLE, LLC	490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. RECEIVED DEC 01 2014 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of the facility's "Resident Fund Management Service Statement" and interview, it was determined the facility failed to refund to the deceased resident's estate the balance of the resident's account within 30 days for 3 of 3 (Resident #133, 182 and 183) sampled residents of the 44 residents included in the stage 2 review. The findings included: 1. Review of the facility's "Refunds" policy documented, "...Private funds or credits should be refunded within 30 days post discharge of a resident or according to state requirements if there are no other outstanding balances that could be a resident's liability due on the account..." 2. Review of a physician's telephone order for Resident #133 dated 8/15/14 documented, "...Send to [Named Hospital] via ambulance R/T [related to] low H/H [Hemoglobin and Hematocrit]..." During an interview in the financial office on 10/29/14 at 9:15 AM, the business office manager	F 160	Preparation and submission of this plan of correction by, Dove Health and Rehab of Collierville, LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F 160 1. Monies in resident # 133's trust fund account were distributed to resident # 133's power attorney on 11-19-14 by the Business Office Manager. Monies in resident # 182's trust fund account were distributed to the State of Tennessee on 11-19-14 by the Business Office Manager. Monies in resident # 183's trust fund account were distributed to the resident, which residues in another Long Term Care Facility on 11-19-14 by the Business Office Manger. 2. On 11-25-14, 31 of 31 resident trust funds who are deceased or discharged greater than 30 days were audited by the business office further issues were identified at that time. 3. The Business Office Manager was in-serviced in regards to reimbursement of the balance of resident funds to residents who are deceased or discharged from the facility on 11-19-14 by the Business Office Coordinator. 4. Beginning the week of 11-23-14, an audit of 3 resident's trust fund accounts of residents who are discharged from the facility will be conducted by the Business Office Manager to ensure funds are reimbursed. The audits will be conducted 3 times weekly for 1 month, weekly for 1 month, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator will be responsible for monitoring and compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

acceptable POC already in place

Felicia Strickland — Administrator — 11-26-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This same POC was faxed 11/26/14

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F 160	Continued From page 1 (BOM) was asked why Resident #133 had not received his refund. The BOM stated, "Resident was discharged to the hospital on 9/1/14. Expired, he was his own responsible party and did not want his daughter to have his money. His daughter was in the process of getting power of attorney because he was having some mental changes. She now has his power of attorney and his money can be refunded back to his daughter." 3. Review of a physician's telephone order for Resident #182 dated 1/19/14 documented, "...Release [Resident #182's] body to [Named Funeral Home]..." During an interview in the financial office on 10/29/14 at 9:30 AM, the BOM was asked why Resident #182's estate had not received her refund. The BOM stated, "The resident expired 1/19/14. Her daughter was her responsible party but not her power of attorney. The resident's money will go back to the state." 4. Review of a physician's telephone order for Resident #183 dated 7/16/13 documented, "...Transports to ER [Named Hospital] dangerous behavior..." The BOM was asked why Resident #183 had not received her refund. The BOM stated, "She was discharged to the hospital on 7/17/13 and did not readmit back into the facility. We were unable to forward her [resident] statement because the resident had an outstanding bill." The BOM was then asked if she ever sent a certified letter to daughter. The BOM stated, "No, I will send out a certified letter to the responsible party today. When it comes back, I [BOM] can forward the resident's existing balance to the state."	F 160		

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F 160	Continued From page 2 5. During an interview in the financial office on 10/29/14 at 9:00 AM, the BOM was asked to describe the facility's refund policy. The BOM stated, "Refund in 30 days. We refund to the family member that is the power of attorney. It then goes to unclaimed money, but that no longer exists. If the resident doesn't have a power of attorney, then we can send the money back to the state."	F 160		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to treat residents with respect and dignity when 3 of 24 staff members (Nurse #1, Nurse #3, and Certified Nursing Assistant (CNA) #1) referred to residents requiring assistance with feeding as a "feeder" and failed to cover a Foley catheter bag for 4 of 26 (Residents #10, 18, 174 and 180) sampled residents included in the stage 2 review. The findings included: 1. Review of the resident rights policy documented, "...9. [The resident] Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy and in care for his personal needs..."	F 241	F 241 1. The three residents who are identified as being dependent on staff for eating were observed by Director of Nursing on 10/31/14; no negative outcome identified. Interviewable residents regarding foley catheter privacy, residing on the 300 hall were interviewed by the Director of Nursing on 10-31-14 to ensure they did not have any signs of mental aguish; no negative issues were identified. Resident # 10's foley catheter was discontinued on 10-29-14 per physician's orders. Residents # 18, # 174, and # 180 were provided with fig leaf privacy bags on 10/31/14 by Director of Nursing. 2. Beginning on 11-1-14 thru 11-10-14,6 meal observations were conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure the staff were using verbiage that is respectful to residents who require assistance with meals; no further negative issues were identified. On 11-1-14, 5 of 5 residents with foley catheters were audited by the Registered Nurse Supervisor, Staff Development Coordinator, Assistant Director of Nursing, and Minimum Data Set Nurse to ensure privacy was maintained; no further negative issues were identified. 3. Beginning on 11-1-14 the nursing staff, including Nurse #1, Nurse #3, and CNA # 1, was in-serviced by the Staff Development Coordinator in regards to using verbiage that is respectful to residents who require assistance with meals.	

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F 241	Continued From page 3 2. Observations on the 300 hall on 10/26/14 at 12:51 PM, Nurse #1 stated, "The rest is feeders." 3. Observations on the 300 hall on 10/28/14 at 7:45 AM, Nurse #3 asked CNA #2, "Do you have [Named Resident] he's going to be a feeder?" Observations on the 300 hall on 10/28/14 at 8:00 AM, Nurse #3 stated to CNA #2, "[Named Resident] is going to be a feeder." 4. Observations on the 300 hall on 10/28/14 at 7:55 AM, CNA #1 stated, "He's [referring to a resident] a feeder." There were residents and other staff members in the hall when this was said. 5. During an interview in the staff development room on 10/29/14 at 7:35 AM, the Assistant Director of Nursing (ADON) was asked if she would expect nurses or staff to call residents who need assistance with feeding a "feeder". The ADON stated, "No Ma'am they are not feeders." 6. Observations in Resident #10's room on 10/26/14 at 11:57 AM, 3:57 PM, and on 10/27/14 at 7:28 AM, revealed Resident #10 lying in the bed with a urinary catheter bag on the bedside without a privacy bag or cover over the bag. During an interview in Resident #10's room on 10/27/14 at 2:49 PM, Resident #10's mother stated, "They [staff] said that catheter is suppose to be in privacy bag. They just put a cover over it." 7. Observations in Resident #18's room on 10/26/14 at 9:00 AM and 12:35 PM, on 10/27/14 at 3:20 PM and on 10/28/14 at 8:00 AM, revealed	F 241	Beginning on 11-1-14 the nursing staff was in-serviced by the Staff Development Coordinator in regards to providing privacy covers to residents with foley catheters. 4. Beginning the week of 11-23-14, meal observations will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure staff use verbiage that is respectful to residents who require assistance with meals. The meal observations will be conducted 3 times weekly for 4 weeks, 1 time a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14, an audit of residents with foley catheters will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure foley bags are covered/fig leaf bags are utilized. The audits will be conducted 3 times a week for 4 weeks, 1 time a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the meal observations and foley catheter audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14 F 253 1. On 10-31-14 Maintenance removed the paint splatters from rooms 114 and 120. On 11-7-14 Housekeeping cleaned the edges and corners of the bathroom floor in room 120. On 10-31-14 Maintenance replaced the commode chair and commode seat in the bathroom of room 124. On 11-7-14 Housekeeping cleaned the cove base and corners in the bathroom of room 124.	

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F 241	Continued From page 4 Resident #18 lying in the bed with a urinary catheter bag on the bedside without a privacy bag or cover over the bag. 8. Observations in Resident #174's room on 10/26/14 at 12:50 PM and 4:09 PM, revealed Resident #174 lying in the bed with a urinary catheter bag on the bedside without a privacy bag or cover over the bag. 9. Observations in Resident #180's room on 10/26/14 at 4:15 PM, revealed Resident #180 lying in the bed with a urinary catheter bag on the bedside without a privacy bag or cover over the bag. 10. During an interview in the staff development room on 10/29/14 at 7:38 AM, the ADON was asked if she expected Foley catheter bags to be covered. The ADON stated, "Yes, they should be in what we call a Fig Leaf Bag. All residents should have one, its a dignity issue, at no time should a Foley bag be exposed to the public."	F 241	On 10-31-14 Maintenance replaced the privacy curtain and hooks in room 200. On 10-31-14 Housekeeping cleaned the floor, edges, corners, and cove base of room 201. On 11-10-14 Maintenance cleaned and repaired the area behind the commode in the bathroom of room 201. On 11-10-14 Housekeeping cleaned the edges, corners, cove base, and threshold in the bathroom of room 202. On 10-31-14 Housekeeping cleaned the wheel chair in room 203. On 10-31-14 the percutaneous endoscopy gastrostomy syringe and nebulizer mask in room 204 were discarded and replaced by director of nursing. On 10-26-14 the nutritional supplements in room 204 were removed and discarded by director of nursing. On 10-31-14 Housekeeping cleaned the wall above the bedside, corners, and edges of the bathroom in room 204. On 10-31-14 Housekeeping cleaned the corners of the bathroom in room 205. On 10-31-14 the Housekeeping Supervisor cleaned the corners of room 206. On 10-4-14 the Housekeeping Supervisor cleaned the edges and corners in the room of 208 and the edges and corners in the bathroom of 208. On 11-10-14 Maintenance replaced the cove base on the corner wall, removed the paint spots on the floor, and repainted the door facing going into the bathroom of room 208. On 11-5-14 Housekeeping cleaned the commode chair over the commode in the bathroom of room 208.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on review of job descriptions, observation and interview, it was determined the facility failed to ensure housekeeping and maintenance services maintained a clean, sanitary, orderly and comfortable environment in residents' rooms as	F 253		

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F 253	Continued From page 5 evidenced by missing hooks on privacy curtains, bathroom floors dirty and with build up in the corners and under sinks, paint splatters on the bathroom floors, peeling paint, dried brown substance on the toilet seats and wheelchair seats, an uncovered nebulizer mask and offensive odors in 17 of 51 (Rooms 114, 120, 124, 200, 201, 202, 203, 204, 205, 206, 208, 216, 218, 223, 320, 324 and 325) resident rooms. The findings included: 1. Review of the facility's contracted housekeeping services job description documented, "...Cleans floor in residents' room: Dry mops, wet mops, sweep and disinfects... Cleans bathrooms in residents' rooms: Cleans and disinfects sinks, mirrors, pipes; the commode tank, bowl and base; then all fixtures, floors, and walls as directed... cleans and disinfects wheelchairs as necessary and assigned..." Review of the the facility's "Housekeeper/Aide Job Description... Environmental Services" documented, "...The Housekeeper/Aide Provides cleaning services within the facility to promote sanitary, comfortable and homelike environment for residents, staff and the public..." 2. Observations on the 100 hall revealed the following: a. Room 114 - on 10/27/14 at 3:37 PM - paint splatters on the bathroom floor. b. Room 120 - on 10/27/14 at 3:29 PM - dirt build up and paint splatters on the floor around the edges of the bathroom and corners. c. Room 124 - on 10/27/14 at 3:33 PM - commode chair over the toilet has a rusty back support rod and rust noted on the legs of the	F 253	On 11-6-14 Housekeeping cleaned the edges and corners of room 216. On 11-6-14 Housekeeping cleaned the edges and corners of the bathroom floor in room 218. On 11-5-14 Housekeeping cleaned the commode chair over the commode in the bathroom of room 218. On 11-6-14 the floor in the front of the commode of room 223 was repaired by Maintenance. On 11-11-14 Housekeeping cleaned the corners and edges of the floor in room 320. On 11-11-14 the cove base of the bathroom floor in room 324 was cleaned by Housekeeping. On 11-11-14 the Housekeeping Supervisor cleaned room 325. The room deodorizers were removed from room 325 on 10-31-14 by Director of Nursing. 2. On 10-31-14 the Housekeeping Supervisor conducted an audit 51 of 51 resident rooms and bathrooms was conducted to ensure the cleanliness of the corners, edges, cove base, walls, and commode chairs; issues identified were addressed at that time. On 10-31-14 Maintenance was conducted an audit of 51 of 51 resident rooms in regards to paint splatters on the floors, privacy curtain hooks, commode seats, commode chairs over the commodes, door facings going into the bathrooms, cove base in the rooms, an areas in the wall that have been patched; issues identified will be addressed at that time. On 10-31-14 an audit of 51 of 51 residents rooms was conducted percutaneous endoscopy gastrostomy tube syringes by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure proper storage.	

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F 253	Continued From page 6 chair, paint peeling off the toilet seat, dirty build up on the cove base in corners of the bathroom. 3. Observations on the 200 hall revealed the following: a. Room 200 - on 10/26/14 at 9:10 AM - privacy curtain had missing hooks and was hanging from the rack. b. Room 201 - on 10/26/14 at 9:00 AM - Smells of urine, the bathroom floor dirty with build up around the edges and in the corners, the wall behind the commode has been repaired with white spackling with a black substance and a musty smell with the appearance of mold. On 10/26/14 at 12:35 PM and 3:30 PM - A black substance with the appearance of mold on the wall in bathroom behind the commode and a strong urine odor in the room. On 10/27/14 at 8:27 AM - strong offensive odor in the room, the floor with dirty build up below cove base and in corners of the room. During an interview in room 201 on 10/26/14 at 9:10 AM, Nurse #7 was asked what the black substance on the bathroom wall looked like. Nurse #7 stated, "Looks like mold." c. Room 202 - on 10/26/14 at 9:15 AM - the bathroom floor was dirty with dirt build up around the edges and in the corners with pieces of paper towel on the floor. On 10/26/14 at 12:37 PM - the bathroom with build up around the cove base on the floor and across the threshold. d. Room 203 - on 10/26/14 at 4:42 PM and on 10/27/14 at 7:55 AM - a wheel chair at the bedside had a dried brown substance in the seat. e. Room 204 - on 10/26/14 at 9:20 AM - an uncovered Percutaneous Endoscopy Gastrostomy (PEG) syringe laying on the bedside	F 253	On 10-31-14 an audit of 51 of 51 rooms nebulizer masks was conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure proper storage. On 10-31-14 an audit was conducted of 51of 51 resident rooms by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure nutritional supplements is not stored at the bedside. 3. On 11-7-14 the Housekeeping Supervisor was in-serviced by the Administrator in regards to the cleanliness of the corners, edges, cove base, walls, and commode chairs. On 11-10-14 the Housekeepers were in-serviced by the administrator in regards to the cleanliness of the corners, edges, cove base, walls, and commode chairs. On 11-7-14 the Maintenance Supervisor was in-serviced by the Administrator in regards to paint splatters on the floors, privacy curtain hooks, commode seats, commode chairs over the commodes, door facings going into the bathrooms, cove base in the rooms, an areas in the wall that have been patched. On 11-10-14 the Maintenance Assistant was in-serviced by the Maintenance Director in regards to paint splatters on the floors, privacy curtain hooks, commode seats, commode chairs over the commodes, door facings going into the bathrooms, cove base in the rooms, an areas in the wall that have been patched. On 11-20-14the licensed nurses were in-serviced by the Staff Development Coordinator in regards to the storage of percutaneous endoscopy gastrostomy tube syringes, nebulizer masks, and nutritional supplements.	

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F 253	Continued From page 7 table, the wall above the bedside had dried splatters of yellowish brown spots with the appearance of nutritional supplement (6 cans of of nutritional supplement on the bed side table), a nebulizer mask uncovered laying on top of the nebulizer machine and the bathroom floor was dirty around the edges of the wall and in the corner. f. Room 205 - on 10/27/14 at 7:57 AM - bathroom floor has dirt build up in the corners. g. Room 206 - on 10/26/14 at 9:25 AM - dirt build up in the floor in the corners of the room along the wall. h. Room 208 - on 10/26/14 at 9:30 AM - dirt around the edges and in the corners of the floor in the room. The cove base was missing on the corner of the wall beside the door. The bathroom had dirt build up around the edges and in the corner of the floor. Paint spots on the floor and paint peeling from the door facing going into the bathroom. On 10/27/14 at 8:05 AM the bathroom floor dirty with build up around the edges and in the corners, and the potty chair over the commode had dried brown substance inside around the rim. i. Room 216 - on 10/27/14 at 10:00 AM - the bathroom floor has dirt around the edges and build up in the corners. j. Room 218 - on 10/27/14 at 8:05 AM - the bathroom floor dirty with dirt build up around the edges and in the corners, a potty chair over the commode had dried brown substance inside of the rim. k. Room 223 - on 10/26/14 at 11:56 AM and 3:22 PM, and on 10/27/14 at 8:09 AM and 2:45 PM - the floor in front of the commode in the bathroom with dry, liquid stains noted. 4. Observations on the 300 hall revealed the	F 253	4. Beginning the week of 11-23-14 audits of resident rooms and bathrooms to ensure the cleanliness of the corners, edges, cove base, walls, and commode chairs will be conducted by the Housekeeping Supervisor. The audits will be conducted 3 times a week for 4 weeks, 1 time a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of resident rooms in regards to paint splatters on the floors, privacy curtain hooks, commode seats, commode chairs over the commodes, door facings going into the bathrooms, cove base in the rooms, an areas in the wall that have been patched will be conducted by the Maintenance Supervisor. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of percutaneous endoscopy gastrostomy tube syringes will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure proper storage. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of nebulizer masks will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure proper storage. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of resident rooms will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure nutritional supplements are not stored	

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F 253	Continued From page 8 following: a. Room 320 - on 10/27/14 at 3:16 PM - bathroom floor had dirt build up around the edges and the corners. b. Room 324 - on 10/26/14 at 3:53 PM - dirty build up around the cove base on the bathroom floor. c. Room 325 - on 10/26/14 at 12:48 PM and 4:25 PM, on 10/27/14 at 2:57 PM, and on 10/28/14 at 8:15 AM - very strong offensive odor in the room. There were 6 room deodorizers in this room, 1 was on the shelf beside the resident in the A bed, and 5 were on a tall shelf in front of the resident in the A bed. During an interview in room 325 on 10/27/14 at 6:25 PM, the housekeeping supervisor was questioned about the odor in this resident's room. The housekeeping supervisor stated, "Have tried everything with [pointing to resident in the A bed], it is him, he will not always let the certified nursing assistants [CNAs] clean him, try to clean his mattress when can, don't know what to do." The housekeeping supervisor confirmed there was an odor in room 325. During an interview in room 325 on 10/28/14 at 6:35 PM, CNA #4 confirmed there was an odor in room 325. CNA #4 stated, "He [named resident] refuses care frequently, he is incontinent, will let me care for him, but he refuses to be cleaned up, have had difficulty with this resident refusing care." 5. During an interview while touring the 100, 200 and 300 halls on 10/30/14 at 4:35 PM, the administrator was asked if he saw the housekeeping and cleanliness issues with the halls and the rooms. The administrator nodded	F 253	at the bedside. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. BUILDING _____ B. WING _____	10/30/2014

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F 253	Continued From page 9 his head in confirmation.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to develop a plan of care with measurable goals and interventions to address urinary incontinence for 1 of 23 (Resident #126) sampled residents reviewed of the 44 residents included in the stage 2 review. The findings included:	F 279	F 279 1. Resident # 126's care plan was revised on 10-29-14 by the Minimum Data Set Nurse to reflect occasional urinary incontinence. 2. Beginning on 11-3-14 members of the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) conducted an audit of resident care plans to ensure the care plans accurately reflected the residents' continence status; issues identified were addressed at that time. 3. On 11-20-14 the members of the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) were in-serviced by the Regional Clinical Re-imbursement Nurse in regards to the development and revisions of comprehensive care plans. 4. Beginning the week of 11-23-14 an audit of 3 resident care plans in regards to continence status will be conducted by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services). The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator is responsible for monitoring and compliance.	

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F 279	Continued From page 10 Review of the facility's care plan policy documented, "It is the policy of this facility to develop and maintain a Plan of Care for each resident upon admission and to review such plans at least quarterly... Each Comprehensive Care Plan includes measurable goals and timetables to meet the resident's medical, nursing, psychological, and social needs that are identified in the Comprehensive Assessment..." Medical record review for Resident #126 documented an admission date of 8/13/14 with diagnoses of Anemia, Heart Failure, Diabetes, Hypertension, Non-Alzheimer's Dementia, Anxiety, Depression, Asthma, Respiratory Failure, Chronic Lung Disease, Obstructive Sleep Apnea, Morbid Obesity, Pulmonary Embolism, Tracheostomy, Gastroparesis, Dementia and Hypoventilation Syndrome. Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/18/14 documented Resident #126 as always continent of the bladder. Review of the quarterly MDS with an ARD of 9/17/14 documented Resident #126 as occasionally incontinent of the bladder (less than 7 episodes of incontinence). Review of the "Resident ADL [Activities of Daily Living] Record" for September 2014 documented Resident #126 with incontinent episodes of bladder. Review of the care plan dated 8/14/14 documented, "...require staff assistance for all ADL's... contineent [continent] of bowel amnd [and] bladder to my bedside commode..." here was no care plan for incontinence.	F 279		

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F 279	Continued From page 11 During an interview in front of the 300 hall nurses' station on 10/29/14 at 3:10 PM, the MDS Coordinator was asked about a care plan for incontinence. The MDS Coordinator confirmed there was no care plan for incontinence, and stated, "I don't see a care plan for incontinence, will have to add that."	F 279	F 280 1. Resident # 64 was re-evaluated on 11-11-14 by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) in regards to fall risk and the use of the bed and chair alarms. Resident # 64's attending physician was notified on 11-11-14 by the Director of Nursing and new orders were received to discontinue the bed alarm. After Interdisciplinary Team review on 11-11-14, resident #64's chair alarm was removed and resident # 64's care plan was revised at that time. 2. On 11-24-14 the Director of Nursing conducted an audit of 20 of 20 incidents/ accident reports from the past 90 days to ensure fall interventions were added to the resident's care plan; no further issues were identified at that time. On 11-3-14, 7 of 7 residents were observed by the Director of Nursing and Assistant Director of Nursing to ensure residents with interventions for bed or chair alarms had the alarms intact. In addition, the care plans of residents with interventions for bed or chair alarms were audited at this time; no further issues were identified. On 11-3-14 7 of 7residents with interventions for bed and chair alarms were audited to ensure the resident's Medication Administration Records indicated to check placement and functioning each shift by the assistant director of nursing issues identified were addressed at that time.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on policy review, review of an incident report, medical record review, observation and interview, it was determined the facility failed to revise and update the care plan for falls for 1 of	F 280		

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F 280	Continued From page 12 23 (Resident #64) sampled residents of the 44 residents included in the stage 2 review. The findings included: Review of the facility's falls policy documented, "...It is the policy of this facility to assess residents for the potential for falls and identify factors that might contribute to falls. The facility will address those factors identified in order to reduce the risk for falls... PROCEDURE... 3. If the resident has fallen in the past month, the resident will be considered at high risk regardless of their risk score... 4. The care plan should be updated after a fall to address the most recent cause of the fall..." Medical record review for Resident #64 documented an admission date of 11/23/10 with diagnoses of Malignant Neoplasm of the Colon, Depressive Disorder, History of Fall, Joint Pain, Late Effects of Cerebrovascular Accident, Anxiety State and Lack of Coordination. Review of the nurses' notes dated 5/1/14 documented, "...Resident continues to try and transfer without assistance. w/c [wheelchair] alarm on & [and] working properly..." Review of an incident report dated 10/21/14 documented, "...Incident... Fall... What was position of resident? sitting upright on the floor... What did resident say happened? 'I was trying to get back into bed' ...INVESTIGATION OF INCIDENT... what CAUSED this... incident... Resident attempted to transfer self to bed from wheelchair without assistance... What was done during or immediately after this incident to protect the resident from further injury or risk of injury,	F 280	3. On 11-20-14 the members of the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) were in-serviced by the Regional Clinical Re-imbursement Nurse in regards to the development and revisions of comprehensive care plans. Beginning on 11-18-14 the licensed nurses were in-serviced by the Staff Development Nurse and Director of Nursing in regards to revising the resident's care plan with new fall reduction interventions. 4. Beginning the week of 11-23-14 audits of 3 resident care plans who have sustained a fall will be audited by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing to ensure care plans have been revised with fall reduction interventions. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of 3 residents with interventions for bed and/or chair alarms will be assessed to ensure the alarm is intact and functioning. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

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F 280	Continued From page 13 and to prevent future recurrences of this incident? Reeducated on call light and chair alarm..." Review of the nurses' notes dated 10/21/14 documented, "...Resident states 'I was trying to get back in bed into bed.' Resident has been educated... several times on safety issues. This nurse re-educated resident on safety issues and transfers..." Review of a care plan dated 11/23/10 documented, "...Problem... at risk for falls... Approaches... Bed alarm to alert staff of unassisted transfers... call light use... 10/21/14... Re-educate R/T [related to] asking for transfer assistance..." Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected. The facility did not implement a new intervention on the care plan after the fall on 10/21/14. During an interview in the staff development room on 10/30/14 at 11:45 AM, the Minimum Data Set (MDS) coordinator was asked when the chair alarm was initiated. The MDS Coordinator stated, "I'm not seeing where it was ordered. They usually write an order for it. She [Resident #64] has a history of falls. I can look in overflow." The MDS coordinator was asked, should the wheelchair alarm be included on the care plan. The MDS coordinator stated, "If there was an order written it should be on there. We get the	F 280		

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F 280	Continued From page 14 orders and the incident reports after the DON [Director of Nursing] looks at the incident report and reviews the interventions. The DON puts long term interventions in place and that is what we go by for the care plan. I can't find the order for the wheelchair alarm unless it is in overflow I will check and let you know." During an interview in the staff development room on 10/30/14 at 12:10 PM, the MDS coordinator stated, "I spoke with the DON and she said the chair alarm don't need an order because it is a nursing intervention. I spoke with the nurse that was here when she had the fall and she told me that the chair alarm was put on when she had the fall [10/21/14]." The MDS coordinator was asked if a chair alarm is in use, should it be included on the care plan. The MDS Coordinator confirmed the intervention should be on the care plan. This surveyor again asked when the chair alarm was initiated. The MDS coordinator stated it was 10/21/14 after that fall. This surveyor asked why the chair alarm was documented in the 5/1/14 nurses notes. The MDS coordinator stated, "Do not know, will have to check in overflow." No further explanation was ever provided.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a record of	F 282	F 282 1. Resident # 64 was re-evaluated on 11-11-14 by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) in regards to fall risk and the use of the bed and chair alarms. Resident # 64's attending physician was notified on 11-11-14 by the Director of Nursing and new orders were received to discontinue the bed alarm. After Interdisciplinary Team review on 11-11-14 resident #64's chair alarm was removed and resident # 64's care plan was revised at that time. Resident # 164's care card was revised on 11-19-14 by staffing development coordinator to reflect resident # 164's oral care status and request for a warm, soapy wash cloth in the morning to perform facial and hand hygiene. Resident # 169's Medication Administration Record was revised on 11-1-14 by staffing development coordinator to reflect the need for checking placement and functioning of the bed alarm and chair alarm.	

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F 282	Continued From page 15 concern, medical record review, observation and interview, it was determined the facility failed to follow care plan interventions for bed and chair alarms, implement care plan interventions for falls and follow the care plan for Activities of Daily Living (ADLS) assistance for 3 of 23 (Residents #64, 164 and 169) sampled residents of the 44 residents included in the stage 2 review. The findings included: 1. Review of the facility's falls policy documented, "...It is the policy of this facility to assess residents for the potential for falls and identify factors that might contribute to falls. The facility will address those factors identified in order to reduce the risk for falls... PROCEDURE... 3. If the resident has fallen in the past month, the resident will be considered at high risk regardless of their risk score... 4. The care plan should be updated after a fall to address the most recent cause of the fall..." 2. Medical record review for Resident #64 documented an admission date of 11/23/10 with diagnoses of Malignant Neoplasm of the Colon, Depressive Disorder, History of Fall, Joint Pain, Late Effects of Cerebrovascular Accident, Anxiety State and Lack of Coordination. Review of a care plan dated 11/23/10 documented, "...Problem... at risk for falls... Approaches... Bed alarm to alert staff of unassisted transfers..." Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not	F 282	2. On 11-3-14 11 of 11 residents were observed by the Director of Nursing and Assistant Director of Nursing to ensure residents with interventions for bed or chair alarms were intact. In addition, the care plans of residents with interventions for bed or chair alarms were audited at this time; no further issues were identified. On 11-24-14 the Director of Nursing conducted an audit of 20 of 20 incidents/ accident reports from the past 90 days to ensure fall interventions were added to the resident's care plan; no further issues were identified at that time. On 11-19-14 an audit of 100 of 100 resident's care cards were audited by the staff development to ensure the reflection of oral care status and any special request made by the residents for morning care; issues identified were addressed at that time. On 11-1-14, 7 of residents of 7 residents with interventions for bed and chair alarms were audited to ensure the resident's Medication Administration Records indicated to check placement and functioning each shift by Assistant Director of Nursing and RN supervisor; issues identified were addressed at that time. 3. Beginning on 11-19-14 the Staff Development Coordinator in-serviced nursing staff in regards to the revision and the following of the resident's care plan and care card for Activities of Daily Living, and the following care plans and care cards for placement of chair and bed alarms, implementation of interventions to reduce potential of falls. Licensed nurses were in-serviced in regards to adding interventions for chair and bed alarms to the resident's Medication Administration Record to ensure placement and functioning are checked each shift.	

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F 282	Continued From page 16 connected to Resident #64. There was an alarm hanging under the bed and that alarm was not connected. Observations in Resident #64's room on 10/28/14 at 2:50 PM, revealed Resident #64 sitting up in a wheelchair at bedside. There were 2 alarms hanging on the bed rail and neither was attached to Resident #64. Observations in the therapy room on 10/28/14 at 3:45 PM, revealed Resident #64 sitting in her wheelchair. There was no alarm on Resident #64's wheelchair or clipped to her. The facility was not following the care plan interventions for alarms. During an interview in Resident #64's room on 10/28/14 at 3:00 PM, Certified Nursing Assistant (CNA) #6 was asked if either of the alarms was connected to the resident. CNA #6 stated, "No ma'am. I just took it off when I got her up." CNA #6 was then asked if the alarm should be on the resident. CNA #6 stated, "I have never put it on her when she is up and going to therapy." During an interview in Resident #64's room on 10/28/14 at 8:20 AM, Nurse #5 was asked why there were 2 alarms on Resident #64's bed. Nurse #5 stated, "I don't know" and began looking at the alarms. Nurse #5 stated, "That one is her chair alarm, they take it off and put it on the chair when she is up." Nurse #5 was then asked why there was an alarm under the resident's bed. Nurse #5 stated, "That one is a pressure alarm sensor on the mattress." Nurse #5 was asked if the sensor alarm was connected. Nurse #5 stated, "No, it is not." Nurse #5 was asked if the	F 282	4. Beginning the week of 11-23-14 audits of 3 residents with interventions for bed and/or chair alarms will be assessed to ensure the alarm is intact and functioning. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 audits of 3 resident care plans who have sustained a fall will be audited by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing to ensure care plans have been revised with fall reduction interventions. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 3 resident's care cards will be audited to ensure they indicate the resident's oral status, Activities of Daily Living status, and any special request made by the resident for morning care. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 3 residents with interventions for bed and chair alarms will be audited to ensure the resident's Medication Administration Records indicated to check placement and functioning each shift by assistant director of nursing. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

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F 282	Continued From page 17 alarms were doing any good since they were not connected. Nurse #5 stated, "No ma'am." 3. Medical record review for Resident #164 documented an admission date of 9/8/14 with diagnoses of Meningioma, Pulmonary Collapse, Ataxia, Hypertension, Hernia, Hypothyroidism, Cardiac Dysrhythmia, Hyperlipidemia and Primary Cardiomyopathy. Review of the admission MDS with an assessment reference date of 9/15/14 documented a Brief Interview for Mental Status (BIMS) score of 9 indicating the Resident #164 was moderately impaired for decision making and required extensive assistance for personal hygiene including brushing her teeth. Review of the 30 day MDS with an assessment reference date of 10/4/14 documented Resident #164 had a BIMS score of 15 indicating Resident #164 was cognitively intact for decision making and required extensive assistance for personal hygiene including brushing her teeth. Review of a care plan dated 9/22/14 documented, "...Problem... require assist of ADL's including oral care... Approaches... Assist... as needed... Do not rush... Allow extra time to complete ADLs as needed... Assist... with bathing, grooming... and other ADLs as needed... Provide... oral care daily and PRN [as needed]..." Review of initial nursing summary dated 9/8/14 documented, "...Daily oral care by... Staff [checked]... Use soft brush or toothettes [checked] Use mouthwash [checked]..." Review of a "CNA CARE CARD" for Resident #164 documented, "...CHECK AND COMPLETE	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 18 ALL ITEMS THAT DESCRIBE RESIDENT'S STATUS... ORAL CARE... Independent... Assisted... Total Care..." The oral care area was not checked to indicate the resident's status for oral care. Observations in Resident #164's room on 10/26/14 at 12:39 PM, the staffing nurse came in Resident #164's room answering Resident #164's call light. Resident #164 was telling the nurse that she wanted a warm soapy wash cloth to wash her face and before she could finish telling the nurse that she wanted the swabs for her mouth, the nurse turned around and walked toward the door to leave the room until she was told by this surveyor that the resident was still trying to talk to her. The staffing nurse then returned to the bedside and asked what else the resident needed. During an interview in Resident #164's room on 10/26/14 at 12:39 PM, Resident #164 was asked if she received the help necessary for cleaning her teeth. Resident #164 stated, "I can do it, but I need my toothbrush and a soapy wash cloth." Resident #164 was asked how often are your teeth/dentures cleaned. Resident #164 stated, "Twice a week maybe." During a discussion with the Director of Nursing (DON) on 10/26/14 at 5:00 PM, the DON was informed of an incident that Resident #164 had reported to the surveyor. Resident #164 reported she was given a shower with her diaper still on, and the diaper was not removed until after her shower was completed. Resident #164 asks and does not always receive a wash cloth to wash her face and a toothbrush to brush her teeth upon request. The resident had not reported this to	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. BUILDING _____ B. WING _____	10/30/2014

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F 282	Continued From page 19 anyone until she reported to the surveyor on 10/26/14. Review of a record of concern dated 10/26/14 that was provided by the DON only documented an investigation for the concerns of being bathed with a diaper on, there was no documented investigation of the concerns related to requesting wash cloths or a tooth brush. During an interview in Resident #164's room on 10/28/14 at 9:50 AM, Resident #164 stated, "I want a warm soapy wash cloth to wash my face and hands. I ate breakfast and my fingers are sticky and I would like to wash my face. I can do it if they would just bring me a warm soapy wash cloth. I asked for one but they told me they didn't have any up here yet. If I could get that and some of those little good tasting sticks that you put in your mouth I could wipe my teeth off and I will be good." Resident #164 was asked if she had her teeth brushed yet this morning. Resident #164 stated, "No." During an interview in the 200 hall beside the dining room on 10/28/14 at 10:05 AM, CNA #5 was asked if she was assigned to Resident #164. CNA #5 stated, "Yes, but this is only the 2nd time I have had her." CNA #5 was asked how she knows what she is supposed to do for Resident #164 if she hasn't taken care of her that much. CNA #5 stated, "I talk to the other CNAs that have taken care of her and we have this [indicating a CNA care card]." CNA #5 was asked if I look at the care card and it is marked supervision for bathing, if that means the resident can do her own bath and you just have to set up for her. CNA #5 stated, "I do it for her." CNA #5 was asked how would you know what to do for her mouth	F 282		

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F 282	Continued From page 20 care since nothing is marked. CNA #5 stated, "You wouldn't know how to do mouth care." CNA #5 stated, "The CNA before me gives her mouth care. She gets it daily." CNA #5 stated, "If she is already up, I keep her dry. If she is not up I wash her face, bathe her and put her clothes on." During an interview in the staff development room on 10/28/14 at 3:20 PM, the DON was asked if she had addressed the concerns from Resident #164 related to her not receiving a wash cloth or her tooth brush in the mornings. The DON stated, "No, I have not. I was more concerned with the other issue, but I will." During an interview in the staff development room on 10/28/14 at 3:55 PM, the DON was asked where the CNAs document their ADL care when it is done. The DON stated, "They have a book on each floor that they document this in I think they have 2 on each floor." 4. Medical record review for Resident #169 documented an admission date of 10/09/14 with diagnoses of Gastrointestinal Hemorrhage, Heart Failure, Diabetes Mellitus, Hyperlipidemia and Alzheimer's Disease. Review of the care plan dated 10/19/14 documented, "...Risk for falls related to recent falls... bed/chair alarm as ordered, check placement and function Q [every] shift..." Review of the Medication Administration Record (MARS) for October 2014 documented, "...Bed Alarm,Chair Alarm Landing strips Applied to bilateral Bed... 7A-7P... 7P-7A..." There was no documentation assessing that the bed and chair alarm was functioning or in place.	F 282		

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F 282	Continued From page 21 During an interview at the 300 hall nurses' station on 10/28/14 at 5:30 PM, Nurse #2 was asked how does she check placement and function of bed and chair alarms. Nurse #2 stated, "I just put my hand on the pad where it is on the bed or the chair and raise my hand up and it should alarm. Nurse #2 was asked where is it documented that it was checked. Nurse #2 stated, "On the MARS every shift." During an interview at the 300 hall nurses' station on 10/28/14 at 5:45 PM, Nurses #3 was asked to view the MARS where it was documented the bed and chair alarm was checked every shift. Nurse #3 stated, "Here [pointing at the MARS] is where it is supposed to be." Nurse #3 confirmed there was no documentation the placement and functioning was being assessed, as care planned.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide the necessary care and services related to physician ordered medications or complete a pain assessment for 2 of 23	F 309	F 309 1. Resident # 128 was discharged from the facility on 06-19-14. Resident # 173 was discharged from the facility on 11-3-14. 2. Beginning on 11-3-14 the Medical Records Nurse conducted an audit of 83of 83 resident's Medication Administration Records who have been discharged within the past 3 months; no further issues were identified.	

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F 309	Continued From page 22 (Residents #128 and 173) sampled residents reviewed for medication use of the 44 residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #128 documented an admission date of 5/27/14 with diagnoses of Obstructive Chronic Bronchitis with Exacerbation, Chronic Airway Obstruction, Chronic Respiratory Failure, Emphysema, Dysphagia, Speech and Language Disorder and Tobacco Use Disorder. Review of the physician admission orders dated 5/27/14 documented, "...Flucanazole 200 mg. [milligrams] i [1] po [by mouth] QD [every day]... Nicotine Patch 14 mg / [every] 24 [sign for hours] i patch topically QD... Nystatin 100,000 units / ml [milliliter] suspension take 5 ml po QID [four times a day]... Omeprazole 20 mg i po Q AM [morning]... Prednisone 10 mg i po QD... Alprazolam 1 mg i po QID... Amlodopine 2.5 MG i PO qd... B COMPLEX i PO qd... MVI [Multivitamin]... i po QD... Doxepin 50 mg i po Q HS [hour of sleep]... Levofloxacin 750 mg i po QD x [times] 4 days... Lexapro 10 mg i po TID [three times a day] Megestrol 400 mg/10ml po QD... Potassium Chloride 10 MEQ [milliequivalents] ii (20 MEQ) po BID... Spiriva handihaler inhalation i inhalation QD..." The medication administration record for May 2014 was requested and not provided. The facility did not follow physician's orders for administration of medications to Resident #128 from 5/27/14 through 5/31/14. 2. Review of the facility's pain management	F 309	Beginning on 11-25-14 the Assistant Director or of Nursing conducted an audit of 52 of residents of 52 resident's pain management flow records who are receiving pain medication to ensure the documentation of the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention was provided; issues identified were addressed at that time. 3. Beginning the week of 11-25-14 the Director of Nursing and Staff Development Coordinator in-serviced the Medical Records Nurse, Medical Records Assistant, and the licensed nurses on the process of removing and filing the Medication Administration Records of discharged residents. Beginning the week of 11-20-14, the Staff Development Coordinator in-serviced the licensed nurses in regards to the documentation of the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention is provided on the resident's pain management flow record. 4. Beginning the week of 11-23-14, 3 clinical records of residents who have been discharged from the facility will be audited by the Medical Records Nurse and/or Medical Records Assistant to ensure the resident's most recent Medication Administration Records are filed in the closed record. The audits will be conducted weekly for 4 weeks, then monthly for 3 months and quarterly thereafter. Beginning the week of 11-23-14, 3 residents pain management flow records will be audited by the Registered Nurse Supervisor, Assistant Director of Nursing, and/or Staff Development Coordinator to ensure documentation reflects the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention is provided. The audits will be conducted weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter.	

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F 309	Continued From page 23 policy documented, "It is the policy of this facility to screen residents for pain and further assess if indicated for cause and severity of pain as well as what relieves the pain. All residents should receive treatment for pain relief as warranted and then monitored for effectiveness... A pain scale of 0- [to] 10 (0 = [means] no pain, 10 = worst pain) should be utilized for the adult resident..." Medical record review for Resident #173 documented an admission date of 10/16/14 with diagnoses of Congestive Heart Failure, Hypertension, Hyperlipidemia and Venous Ulcer of the Lower Left Leg and Left Inner Ankle. Review of the cognitive performance scale dated 10/16/14 documented the resident's decisions were consistent and reasonable, was able to make himself understood, had no short-term memory problems, and had no cognitive impairment. Review of the admission pain assessment dated 10/16/14 documented the resident's pain intensity in the past 5 days was rated between moderate and severe and what relieved the pain was Lortab 10/325 milligrams (mg). Review of Resident #173's pain management flow sheet part of the Medication Administration Sheet (MAR), for October 2014, documented no assessment of the resident's pain rating, the method used to relieve the pain, or the reassessment of the pain rating after the intervention was provided. Review of a physician's order dated 10/16/14 documented the resident was to be given the pain medication, Lortab 10/325 mg (10 mg of hydrocodone and 325 mg of acetaminophen) one	F 309	The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

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F 309	Continued From page 24 by mouth every 6 hours as the resident needed for pain control. The wound specialist's order dated 10/23/14 increased the frequency of the Lortab to every 4 hours as needed due to uncontrolled pain. During an interview in Resident #173's room on 10/27/14 at 8:40 AM, Resident #173 stated Lortab 10/325 relieves his pain. During an interview in the staff development room on 10/29/14 at 10:10 AM, the Director of Nursing (DON) was asked, if the nurses should be documenting the assessment and reassessment of a resident's pain. The DON stated, "Yes" and indicated the resident's pain documentation should be recorded on the "pain management flow sheet.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a record concern, observation, and interview, it was determined the facility failed to provide assistance with Activities of Daily Living (ADLS) for 1 of 2 (Resident #164) sampled residents of the 10 residents who were interviewed about ADLS. The findings included: Medical record review for Resident #164	F 311	F 311 1. Resident # 164's care card was revised on 11-19-14 by staffing & development coordinator to reflect resident # 164's oral care status and request for a warm, soapy wash cloth in the morning to perform facial and hand hygiene. 2. On11-19-14 an audit of 100 of 100 residents care cards were audited to ensure the reflection of oral care status and any special request made by the residents for morning care; issues identified were addressed at that time. 3. Beginning on 11-20-14 the Staff Development Coordinator in-serviced nursing staff in regards to the revision and the following of the resident's care cards for Activities of Daily Living, including oral care, and any special requests made by the resident in regards to morning care. 4. Beginning the week of 11-23-14, 3 resident's care cards will be audited to ensure they indicate the resident's oral status, Activities of Daily Living status, and any special request made by the resident for morning care. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

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F 311	Continued From page 25	F 311		

documented an admission date of 9/8/14 with diagnoses of Meningioma, Pulmonary Collapse, Ataxia, Hypertension, Hyperlipidemia, Hernia, Cardiac Dysrhythmia, Primary Cardiomyopathy, and Hypothyroidism.

Review of the admission Minimum Data Set (MDS) with an assessment reference date of 9/15/14 documented a Brief Interview for Mental Status (BIMS) score of 9 indicating Resident #164 was moderately impaired for decision making and required extensive assistance for personal hygiene including brushing her teeth. Review of the 30 day MDS with an assessment reference date of 10/4/14 documented Resident #164 had a BIMS score of 15 indicating Resident #164 was cognitively intact for decision making and required extensive assistance for personal hygiene including brushing her teeth.

Review of a care plan dated 9/22/14 documented, "...Problem... require assist of ADL's including oral care... Approaches... Assist... as needed... Do not rush... Allow extra time to complete ADLs as needed... Assist... with bathing, grooming... and other ADLs as needed... Provide me oral care daily and PRN [as needed]..."

Review of initial nursing summary dated 9/8/14 documented, "...Daily oral care by... Staff [checked]... Use soft brush or toothettes [checked] Use mouthwash [checked]..."

Review of a certified nursing assistant (CNA) care card for Resident #164 documented, "...CHECK AND COMPLETE ALL ITEMS THAT DESCRIBE RESIDENT'S STATUS... ORAL CARE... Independent... Assisted... Total Care..." The oral care area was not checked to indicate the

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F 311	Continued From page 26 resident's status for oral care. Observations in Resident #164's room on 10/26/14 at 12:39 PM, the staffing nurse came in Resident #164's room answering Resident #164's call light. Resident #164 was telling the staffing nurse that she wanted a warm soapy wash cloth to wash her face and before she could finish telling the staffing nurse that she wanted the swabs for her mouth, the nurse turned around and walked toward the door to leave the room until she was told by this surveyor that the resident was still trying to talk to her. The staffing nurse then returned to the bedside and asked what else the resident needed. During an interview in Resident #164's room on 10/26/14 at 12:39 PM, Resident #164 was asked if she received the help necessary for cleaning her teeth. Resident #164 stated, "No, I can do it but I need my toothbrush and a soapy wash cloth, they [staff] won't even bring them to me." Resident #164 was asked how often are your teeth / dentures cleaned. Resident #164 then stated, "Twice a week maybe." During a discussion with the Director of Nursing (DON) on 10/26/14 at 5:00 PM, the DON was informed of an incident that Resident #164 had reported to the surveyor. Resident #164 reported she was given a shower with her diaper still on, and the diaper was not removed until after her shower was completed. Resident #164 asks and does not always receive a wash cloth to wash her face and a toothbrush to brush her teeth upon request. The resident had not reported this to anyone until she reported to the surveyor on 10/26/14.	F 311		

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F 311	Continued From page 27 Review of a record of concern dated 10/26/14 (provided by the DON) only documented an investigation for the concerns of being bathed with a diaper on, there was no documented investigation of the concerns related to requesting wash cloths or a tooth brush. During an interview in Resident #164's room on 10/28/14 at 9:50 AM, Resident #164 stated, "I want a warm soapy wash cloth to wash my face and hands. I ate breakfast and my fingers are sticky and I would like to wash my face. I can do it if they would just bring me a warm soapy wash cloth. I asked for one but they told me they didn't have any up here yet. If I could get that and some of those little good tasting sticks that you put in your mouth I could wipe my teeth off and I will be good." Resident #164 was asked if she had her teeth brushed yet this morning. Resident #164 stated, "No." During an interview in the 200 hall beside the dining room on 10/28/14 at 10:05 AM, CNA #5 was asked if she was assigned to Resident #164. CNA #5 stated, "Yes, but this is only the 2nd time I have had her." CNA #5 was asked how she knows what she is supposed to do for Resident #164 if she hasn't taken care of her that much. CNA #5 stated, "I talk to the other CNAS that have taken care of her and we have this [indicating a CNA care card]." CNA #5 was asked if the surveyor could look at the care card. The care card was marked supervision for bathing. CNA #5 was asked if that meant the resident can do her own bath and you just have to set up for her. CNA #5 stated, "I do it for her." CNA #5 was asked how would you know what to do for her mouth care since nothing is marked. CNA #5 stated, "You wouldn't know how to do mouth	F 311		

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F 311	Continued From page 28 care." CNA #5 stated, "The CNA before me gives her mouth care. She [Resident #164] gets it daily [mouth care]." CNA #5 stated, "If she is already up, I keep her dry. If she is not up I wash her face, bathe her and put her clothes on." During an interview in the staff development room on 10/28/14 at 3:20 PM, the DON was asked if she had addressed the concerns from the resident related to her not receiving a wash cloth or her tooth brush in the mornings. The DON stated, "No, I have not I was more concerned with the other issue, but I will." During an interview in the staff development room on 10/28/14 at 3:55 PM, the DON was asked where the CNAs document their ADL care when it is done. The DON stated, "They have a book on each floor that they document this in I think they have 2 on each floor." There was no documentation in the medical record that ADL care was being done. Review of the facility's follow up investigation signed by the DON dated 10/28/14 documented, "She [Resident #164] said she also had a toothbrush brought to her and put into the top drawer of her bedside table with a emesis basin to brush her teeth. She said that she could reach her drawer and would call for assistance if needed to get any personal care items."	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	F 314 1. Resident # 128 was discharged from the facility on 6-19-14. 2. Beginning on 10/31/14 the Licensed Nurses, the Treatment Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Development Nurse conducted body audits on 99 of 99 residents no negative issues were identified at that time.	

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F 314	Continued From page 29 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to provide treatments, assessments and provided treatments without an order for 1 of 2 (Resident #128) sampled residents reviewed of the 2 residents with pressure ulcers. The findings included: Medical record review for Resident #128 documented an admission date of 5/27/14 and a discharge date of 6/19/14 with diagnoses of Obstructive Chronic Bronchitis with Exacerbation, Chronic Airway Obstruction, Emphysema, Chronic Respiratory Failure, Dysphagia, Speech and Language Disorder and Tobacco Use Disorder. Review of an initial nursing summary dated 5/27/14 documented, "SKIN CONDITION... SKIN INTEGRITY BREAKS: dressing [buttocks on diagram] dry and Intact... [LEFT BLANK]..." There was no skin assessment documented for the skin under the dressing of the buttock area. Review of Resident #128's care plan documented the following: a. 5/27/14 - "Problem... at risk for skin breakdown due to paraplegia... Approaches... Provide... pressure reducing surfaces on bed and chair..."	F 314	Beginning the week of 11-3-14 the Treatment Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Development Nurse conducted an audit of 6 of 6 residents identified with pressure ulcers to ensure treatments were ordered by the physician, treatment orders were being administered per the physician's orders, and pressure ulcer assessments were being conducted weekly; no negative issues were identified at that time. 3. The Director of Nursing in-serviced the Treatment/licensed Nurses on 10-31-14 and 11-19-14 in regards to removal of dressings and skin evaluation upon admission, conducting and documenting skin assessments, documentation of the correct dates on the Treatment Administration Records, and obtaining treatment orders from the physician. 4. Beginning the week of 11-23-14 the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) will conduct audits of 3 resident's clinical records who have been newly admitted to the facility to ensure dressings were removed, if applicable, and a skin assessment was performed, during the morning clinical meeting. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) will conduct an audit of treatments of residents having pressure ulcers to ensure treatments were ordered by the physician, treatment orders are being administered per the physicians orders, and pressure ulcer assessments are being conducted weekly. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter.	

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	445495	A. BUILDING _____ B. WING _____	10/30/2014

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F 314	Continued From page 30 b. 6/12/14 - "...pressure ulcer/ Sacrum... Approaches... weekly evaluation of wound healing... need a full skin evaluation weekly with bath/shower..." Review of a "Daily / Weekly / Monthly Body Audit and Hydration Report" dated May 2014 did not document any concerns of the skin. The nurses notes did not have documentation of a coccyx or sacral wound assessment for 5/27/14, 5/28/14, 5/29/14 or from 6/8/14 to 6/12/14. Review of wound and skin status reports documented the following: a. Identified on 5/27/14 Resident #128 had a pressure ulcer (not staged) to his sacrum. b. 5/28/14 - Resident #128 had a DTI to his coccyx. c. 6/8/14 - Resident #128 had a stage 2 pressure ulcer to his sacrum. d. 6/12/14 - Resident #128 had an unstageable wound to his sacrum. Review of skin inspection reports documented the following: a. "5/27/14 Skin Not Intact..." b. "5/28/14 Skin Intact..." c. "6/3/14 Skin Not Intact..." d. "6/10/14 Skin Not Intact..." e. "6/12/14 Skin Not Intact..." f. "6/17/14 Skin Not Intact..." g. "6/19/14 Skin Not Intact..." There was no complete assessment of the skin on the skin inspection reports. Review of skin alert/body alert documentation revealed the following:	F 314	Beginning the week of 11-23-14, the Licensed Nurses, Treatment Nurses, and/ or the Registered Nurse Supervisors, will conduct weekly skin assessments on the residents. The assessments will be reconciled against the resident census by the Assistant Director of Nursing and/ or Registered Nurse Supervisor weekly. Beginning the week of 11-23-14, the Certified Nursing Assistants will conduct body audits on the residents three times weekly. The assessments will be reconciled against the resident census by the Assistant Director of Nursing, Treatment Nurse, and/or Registered Nurse Supervisor 3 times weekly. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

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F 314	Continued From page 31 a. 5/28/14 did not document any concerns of the skin on Resident #128's buttocks. b. 6/5/14 - Resident #128 had mild redness noted on his buttocks with a circle around the area. c. 6/11/14 - an area of concern on Resident #128's buttocks with a circle around the area. Review of Resident #128 wound care specialist evaluation forms documented the following: a. 5/29/14 - an unstageable (full thickness skin or tissue loss- depth unknown) deep tissue injury (localized area of discolored intact skin or blood filled blister) of the coccyx that resolved on 5/29/14 but had been present greater than 2 days. b. 6/12/14 - a stage 3 (full thickness skin loss subcutaneous fat may be visible) pressure wound of the sacrum with recommendations for wound care. c. 6/19/14 - an unstageable wound of the sacrum with recommendations for wound care. The facility was unable to provide documentation of any braden scale assessments completed. Review of a wound healing progress report documented on 6/8/14, 6/12/14 and 6/19/14 that Resident #128 had an unstageable pressure ulcer of the sacrum. Review of a Patient at High Risk (PAR) notes documented the following: a. Week 1 dated 5/28/14 - "...Resident admitted c... PU [pressure ulcer]..." b. Week 2 dated 6/5/14 - did not document any skin concerns. c. Week 3 dated 6/11/14 - "...n.o [new order] to cleanse sacral opening c wound cleanser, pat dry, & [and] apply hydrocolloid q 3 days..."	F 314		

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F 314	Continued From page 32 Review of the May 2014 Medication Administration Record (MAR) documented the wound treatment to cleanse sacral wound with wound cleanser, pat dry and apply hydrocolloid every 3 days was documented as being done on 5/8/14 through 5/11/14. Resident #128 was not admitted until 5/27/14. Review of the MAR dated 5/2014 (the Director of Nursing (DON) stated this was actually a MAR for 6/2014, and was an inaccurate date) documented, "...cleanse sacral wound c [with] wound cleanser, pat dry, apply hydrocolloid q [every] 3 days until further order..." There were no treatments on the MAR for 5/27/14, 5/28/14 or 5/29/14. Review of the MAR dated 6/2014 documented, "...Cleanse wound to sacrum c wound cleanser. Pat dry. Cover c Calcium Alginate QOD [every other day] x [times] 7 days. 6/12/14..." These treatments were documented as being done yet, there was no physician order documented for this treatment change. During an interview in the staff development room on 10/28/14 at 4:25 PM, Treatment Nurse #1 stated, "I don't stage. The only time I measure the wound is when a resident comes in and I measure it. Then call [named wound care doctor] and she tells me what to put down for assessments." Treatment Nurse #1 stated, "The wound care doctor and the doctor does the measurements and I will write down the doctors's measurements and then place them in the computer for the facility's documents. The wound care doctor keeps the documentation that she writes, the only information the facility has for	F 314		

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F 314	Continued From page 33	F 314		

assessments is the dictation from the wound care doctor once it is documented. The facility does not need the information and we do not keep a copy. The certified nursing assistants (CNAs) and nurses do skin assessments with the baths. The nurses also use the skin audit sheet, the nurse completes the form, and gives to the treatment nurse, and after 3 months, they are discarded." Treatment Nurse #1 was asked about Resident #128's pressure ulcer. Treatment Nurse #1 stated, "He had a DTI when he came in [5/27/14]." Treatment Nurse #1 was asked if the nurses notes had any wound documentation. Treatment Nurse #1 stated, "No ma'am. I don't see any."

During an interview in the staff development room on 10/28/14 at 5:00 PM, the Nurse Consultant was asked for a policy for skin assessments and wound care. The Nurse Consultant stated, "If a resident is deemed high risk they go through PAR this is our interdisciplinary team. We discuss patient's at risk, discuss patient's needs with the RD [Registered Dietician] and if needs equipment like a mattress. This is all we've got. We don't have a written protocol. I can tell you our process." The Nurse Consultant was asked how do the nurses know what to do if there is no policy. The Nurse Consultant stated, "We have a Braden Scale."

During an interview in the staff development room on 10/28/14 at 5:15 PM, the Nurse Consultant was asked if a resident is admitted with a dressing on his buttocks, what should the nurses do. The Nurse Consultant stated, "They [nurses] should have taken it [the dressing] off and looked at the skin." There was no documentation of a skin assessment provided when the resident was

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F 314	Continued From page 34 admitted. During an interview in the staff development room on 10/29/14 at 10:35 AM, the wound care doctor was asked where the information for the unstageable DTI of the coccyx came from on the dictated form. The wound care doctor stated, "I remember looking for it and it not being there." The wound care doctor was asked where she receives her information from if she is not in the building and the facility has a pressure ulcer. The wound care doctor stated, "If they are suspicious or they see something they will call me and I tell them what to put down. I will go back and look at it." The wound care doctor was asked about documentation on 6/12/14 where she had documented a stage 3 pressure wound, and what did she remember about this. The wound care doctor stated, "Called me on the weekend, it was [Treatment Nurse], told me how the wound looked, rounds would be later. The treatment nurse can not stage, it is described on the phone and that is what we go by." During an interview in the staff development room on 10/30/14 at 12:35 PM, the Director of Nursing (DON) was asked if the undated and unsigned Daily / Weekly / Monthly Body Audit and Hydration report was considered a body audit and skin assessment. The DON stated, "Yes." The DON was asked what the circled area might be. The DON stated, "An area of concern." The DON stated, "When the wound nurse comes in she should assess the wound." The DON stated, "Yes, should be documented what the wound looks like." The DON was asked about the assessment of wounds. The DON stated, "The computer system we did have was difficult, the staff could not learn it or had difficulty learning it.	F 314		

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F 314	Continued From page 35 The information [named Treatment Nurse #2] would put in did not match the information that [named wound care doctor] had on her notes, the stages never matched.	F 314	F 323 1. Resident # 64 was re-evaluated on 11-11-14 by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) in regards to fall risk and the use of the bed and chair alarms. Resident # 64's attending physician was notified on 11-11-14 by the Director of Nursing and new orders were received to discontinue the bed alarm. After Interdisciplinary Team review on 10-31-14, resident #64's chair alarm was removed and resident # 64's care plan was revised at that time. Resident # 169's Medication Administration Record was revised on 11-1-14 by staffing development coordinator to reflect the need for checking placement and functioning of the bed alarm and chair alarm. The razor was removed from room 210 and discarded in the biohazard/sharps container on 10-31-14 by Director of Nursing. 2. On 10-31-14 7 of 7 residents were observed by the Director of Nursing and Assistant Director of Nursing to ensure residents with interventions for bed or chair alarms were intact. In addition, the care plans of residents with interventions for bed or chair alarms were audited at this time; no further issues were identified. On 11-24-14 the Director of Nursing conducted an audit of 20 incident/ accident reports from the past 90 days to ensure fall interventions were	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of an incident report, observation and interview, it was determined the facility failed to ensure interventions were in place and followed to prevent potential falls for 2 of 3 (Residents #64 and 169) sampled residents with falls and the facility failed to ensure the environment was safe as evidenced by unsecured razors in 1 of 51 (room 210) rooms. The findings included: 1. Review of the facility's falls policy documented, "...It is the policy of this facility to assess residents for the potential for falls and identify factors that might contribute to falls. The facility will address those factors identified in order to reduce the risk for falls... PROCEDURE... 3. If the resident has fallen in the past month, the resident will be considered at	F 323		

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F 323	Continued From page 36 high risk regardless of their risk score... 4. The care plan should be updated after a fall to address the most recent cause of the fall..." 2. Medical record review for Resident #64 documented an admission date of 11/23/10 with diagnoses of Malignant Neoplasm of the Colon, Depressive Disorder, History of Fall, Joint Pain, Late Effects of Cerebrovascular Accident, Anxiety State and Lack of Coordination. Review of the October, 2014 recertification orders documented, "...Bed alarm to alert staff of unassisted transfers [start date 1/4/14]..." Review of an incident report dated 10/21/14 documented, "...Incident... Fall... What was position of resident? sitting upright on the floor... What did resident say happened? 'I was trying to get back into bed' ...INVESTIGATION OF INCIDENT... what CAUSED this... incident... Resident attempted to transfer self to bed from wheelchair without assistance... What was done during or immediately after this incident to protect the resident from further injury or risk of injury, and to prevent future recurrences of this incident? Reeducated on call light and chair alarm..." Review of the nurses' notes dated 10/21/14 documented, "...Resident states "I was trying to get back in bed into bed." Resident has been educated... resident several times on safety issues. This nurse re-educated resident on safety issues and transfers..." Review of a care plan dated 11/23/10 documented, "...Problem... at risk for falls... Approaches... Concave mattress to bed... 1/2 side rails x [times] 2 to bed... Bed alarm to alert staff of unassisted transfers... call light use...	F 323	added to the resident's care plan; no further issues were identified at that time. On 11-1-14, 7 of 7 residents with interventions for bed and chair alarms were audited to ensure the resident's Medication Administration Records indicated to check placement and functioning each shift by assistant director & RN supervisor; issues identified were addressed at that time. On 10-31-14, 51 rooms of 51 rooms were audited by the Registered Nurse Supervisors, Assistant Director of Nursing, and Staff Development Coordinator to ensure razors were not left unattended; no further issues were identified. 3. Beginning on 11-20-14 the Staff Development Coordinator in-serviced the nursing staff in regards to the revision and the following of care plans and care cards for placement of chair and bed alarms. Beginning on 11-20-14 the Staff Development Coordinator in-serviced the licensed nurses in regards to the revision and implementation of care plans with interventions to reduce the potential of falls. Beginning on 11-20-14 the Staff Development Coordinator in-serviced the licensed nurses in regards to adding interventions for chair and bed alarms to the resident's Medication Administration Record to ensure placement and functioning are checked each shift. Beginning on 11-20-14 the Staff Development Coordinator in-serviced the nursing staff in regards to the securing and discarding of razors. 4. Beginning the week of 11-23-14 audits of 3 residents with interventions for bed and/or chair alarms will be assessed to ensure the alarm is intact and functioning.. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter.	

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F 323	Continued From page 37 10/21/14... Re-educate R/T [related to] asking for transfer assistance..." Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected. Observations in Resident #64's room on 10/28/14 at 2:50 PM, revealed Resident #64 sitting up in a wheelchair at bedside. There were 2 alarms hanging on the bed rail and neither was attached to the resident. Observations in the therapy department on 10/28/14 at 3:45 PM, revealed Resident #64 sitting in her wheelchair. There was no alarm on her wheelchair or clipped to the resident. The facility was not following the care plan interventions for alarms and there were no new interventions implemented on the care plan after the fall on 10/21/14. During an interview in Resident #64's room on 10/28/14 at 3:00 PM, Certified Nursing Assistant (CNA) #6 was asked if either of the alarms was connected to the resident. CNA #6 stated, "No ma'am. I just took it off when I got her up." CNA #6 was asked if the alarm should be on the resident. CNA #6 stated, "I have never put it on her when she is up and going to therapy." During an interview in the staff development room on 10/30/14 at 11:45 AM, the Minimum Data Set (MDS) coordinator was asked when the chair	F 323	Beginning the week of 11-23-14 audits of 3 resident care plans who have sustained a fall will be audited by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assistant Director of Nursing to ensure care plans have been revised with fall reduction interventions. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14, 3 residents with interventions for bed and chair alarms will be audited to ensure the resident's Medication Administration Records indicate to check placement and functioning each shift by Assistant director of nursing. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/or Assistant Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 the Registered Nurse Supervisor, Assistant Director of Nursing, Staff Development Coordinator, and Central Supply Nurse will conduct environmental observations to ensure razors are not left unattended. The environmental observations will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

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F 323	Continued From page 38 alarm was initiated. The MDS coordinator stated, "I'm not seeing where it was ordered. They usually write an order for it. She [Resident #64] has a history of falls. I can look in overflow." The MDS coordinator was asked, should the wheelchair alarm be included on the care plan. The MDS coordinator stated, "If there was an order written it should be on there. We get the orders and the incident reports after the DON [Director of Nursing] looks at the incident report and reviews the interventions. The DON puts long term interventions in place and that is what we go by for the care plan. I can't find the order for the wheelchair alarm unless it is in overflow I will check and let you know." During an interview in the staff development room on 10/30/14 at 12:10 PM, the MDS coordinator stated, "I spoke with the DON and she said the chair alarm don't need an order because it is a nursing intervention, I spoke with the nurse that was here when she had the fall and she told me that the chair alarm was put on when she had the fall [10/21/14]." The MDS coordinator was asked if a chair alarm is in use, should it be included on the care plan. The MDS coordinator confirmed the intervention should be on the care plan. This surveyor again asked when the chair alarm was initiated. The MDS coordinator stated it was 10/21/14 after that fall. This surveyor asked why the chair alarm is documented in the 5/1/14 nurses notes. The MDS coordinator stated, "Do not know, will have to check in overflow." No further explanation was ever provided. 3. Medical record review for Resident #169 documented an admission date of 10/09/14 with diagnoses of Gastrointestinal Hemorrhage, Heart Failure, Diabetes Mellitus, Hyperlipidemia and	F 323		

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F 323	Continued From page 39 Alzheimer's Disease. Review of the care plan dated 10/19/14 documented, "...Risk for falls related to recent falls... bed/chair alarm as ordered, check placement and function Q [every] shift..." Review of the Medication Administration Record (MARS) for October 2014 documented, "...Bed Alarm, Chair Alarm Landing strips Applied to bilateral Bed... 7A-7P... 7P-7A..." There was no documentation assessing that the bed and chair alarm was functioning or in place. During an interview at the 300 hall nurses' station on 10/28/14 at 5:30 PM, Nurse #2 was asked how does she check placement and function of bed and chair alarms. Nurse #2 stated, "I just put my hand on the pad where it is on the bed or the chair and raise my hand up and it should alarm. Nurse #2 was asked where is it documented that it was checked. Nurse #2 stated, "On the MARS every shift." During an interview at the 300 hall nurses' station on 10/28/14 at 5:45 PM, Nurses #3 was asked to view the MARS where it was documented that the bed and chair alarm was checked every shift. Nurse #3 stated, "Here [pointing at the MARS] is where it is supposed to be." Nurse #3 confirmed that there was no documentation the placement and functioning was being assessed. 3. Observations in room 210 on 10/26/14 at 9:35 AM, revealed an unsecured razor on the bedside table. During an interview in the staff development room on 10/29/14 at 4:35 PM, the Director of Nursing	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. BUILDING _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 40 (DON) was asked if razors should be left unsecured in resident's rooms. The DON stated, "No, should not be left unattended. During an interview in the staff development room on 10/29/14 at 5:05 PM, the DON stated, "Do not have a policy for unattended / unsecured razors, but it is our protocol to discard the razors after use in biohazard."	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained by 2 of 24 staff members (Certified Nursing Assistant (CNA) #2 and 3) during dining and failed to ensure expired milk was not served, which could have affected 2 of the 20 residents eating in the fine dining room. The findings included: 1. Review of the facility's hand hygiene policy documented, "...Assume every person is	F 371	F 371 1. CNA # 2 and CNA # 3 were in-serviced on 11-4-14 by the Staff Development Nurse in regards to hand hygiene, including emphasis on the washing of hands after each direct resident contact, after contact with inanimate objects/and or after the removal of gloves. Residents # 97 and # 55 were assessed by Director of Nursing on 10-31-14; no negative issues were identified. The chocolate milk was discarded on 10-26-14 by the Assistant Director of Nursing. 2. An observational audit of the meal service was conducted on 11-3-14 by Staffing Development Coordinator to ensure hand hygiene was conducted per requirements; no negative issues were identified at that time. On 10-26-14 and 11-12-14, an audit of the expiration dates of milk was conducted by the Dietary Manager; no negative issues were identified. 3. Beginning on 11-23-14 the Staff Development Coordinator and the Assistant Director of Nursing in-serviced and performed hand hygiene skills checks with the nursihg staff. On 11-12-14 the Administrator in-serviced the Dietary Manager in regards to checking the expiration dates of milk. On 11-12-14 the Administrator in-serviced the dietary staff in regards to checking the expiration dates of milk.	

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F 371	Continued From page 41 potentially infected or colonized with organisms that could be transmitted in the facility and apply the following infection control practices... GUIDELINES... 5. If hands are not visibly soiled, alcohol-based hand rubs are preferred for hand hygiene: A. Before having direct contact with residents... C. After contact with resident's intact skin... E. After contact with inanimate objects..." a. Observations in Resident #97's room on 10/28/14 at 8:00 AM, revealed CNA #2 was assisting Resident #97 with the breakfast meal. CNA #2 got up and repositioned Resident #18, then returned and continued to assist Resident #97 without performing hand hygiene. During an interview in the staff development room on 10/29/14 at 7:35 AM, the Assistant Director of Nursing (ADON) was asked what she expects staff to do when assisting to feed a resident and repositioning another resident. The ADON stated, "Clean their hands and I prefer them to wash their hands." b. Observations in Resident #55's room on 10/26/14 at 12:30 PM, CNA #3 placed a meal tray on the overbed table, applied gloves, assisted Resident #55 up in the bed, touching the resident and the bed, removed her gloves, without performing hand hygiene and continued to set up the tray. During an interview in the staff development room on 10/29/14 at 4:35 PM, the Director of Nursing (DON) was asked what should staff do after touching residents, in between glove use, and passing meal trays. The DON stated, "Should perform hand hygiene."	F 371	4. Beginning on the week of 11-23-14 an observational audit of the meal service will be conducted by the Registered Nurse Supervisor, Assistant Director of Nursing, Director of Nursing, Staff Development Nurse, and/ or the Central Supply Nurse to ensure hand hygiene is performed per requirements. The observational audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning on the week of 11-23-14 an audit of expiration dates of milk will be conducted by the Dietary Manager. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. BUILDING _____ B. WING _____	10/30/2014

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F 371	Continued From page 42 2. Observations in the fine dining room on 10/26/14 at 12:30 PM, revealed 2 cartons of chocolate milk with an expiration date of 10/24/14 in a pan of ice to be served to residents with their lunch meal. There were 20 residents in the dining room for lunch. During an interview in the fine dining room on 10/26/14 at 1:12 PM, the Assistant Director of Nursing (ADON) was asked would you expect chocolate milk that is being served to be expired. The ADON stated, "No, it shouldn't be." The ADON then proceeded to remove it off the tray and put them into the trash.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F 425 1. Resident # 173 was discharged from the facility on 11-3-14. 2. Beginning on 11-3-14, 6 of 6 medication carts were audited for medication availability in comparison with the physician's orders for pain medications by the Director of Nursing and Assistant Director of Nursing; no negative issues were identified. 3. Beginning on 11-20-14 the licensed nursing staff was in-serviced by the Staff Development Coordinator in regards to untimely delivery of pain medications. 4. Beginning on the week of 11-23-14 an audit of pain medications faxed to the pharmacy for fill or refill will be conducted and reconciled to the delivery manifest from the pharmacy by the Licensed Nurse, Registered Nurse Supervisor, Assistant Director of Nursing and/ or Staff Development Coordinator. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility's pharmaceutical provider failed to ensure prescribed pain medications was delivered timely 1 of 23 (Resident #173) sampled residents reviewed for medication use of the 44 residents included in the stage 2 review. The findings included: Medical record review for Resident #173 documented an admission date of 10/16/14 with diagnoses of Congestive Heart Failure, Venous Ulcer of the Lower Left Leg and and Left Inner Ankle, Hyperlipidemia and Hypertension. Review of a physician's prescription for Resident #173's pain medication dated 10/23/14 documented, "Hydrocodone 10/325 [10 milligrams (mg) hydrocodone and 325 mg acetaminophen] i [one] po [by mouth] q [every] 4 h [hours] prn [as needed] pain x [times]14 days...] The facsimile transmission verification report was dated 10/23/14 at 9:30 AM as received by the pharmaceutical provider. Review of a nurse's note dated 10/26/14 at 7:30 PM documented Resident #173 complained of pain. Resident #173's personal prescribed pain medication was not available on the 3rd floor medication cart. During an interview in the dining room on 10/30/14 at 11:00 AM, the pharmaceutical provider's Director of Clinical Operations, was asked why Resident #173's pain medication had	F 425		

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	445495	A. BUILDING _____ B. WING _____	10/30/2014

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DOVE HEALTH & REHAB OF COLLIERVILLE, LLC	490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017

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F 425	Continued From page 44 not been delivered to the facility. The pharmaceutical provider's Director of Clinical Operations stated, "It was an order entry mistake. I realize we failed, had measures in place for pain control, [the facility's Emergency Kit had hydrocodone tablets available]."	F 425	F 431 1. On 11-11-14 Nurses #2 and # 4 were in-serviced by the Staff Development Coordinator in regards to leaving medications unattended. 2. On 11-14-14 medication pass audit by observation was conducted by Assistant Director of Nursing to ensure medications were not left unattended; no negative issues were identified. 3. Beginning on 11-20-14 the licensed nurses were in-serviced by Consultant Pharmacist in regards to not leaving medications unattended and unsecured. Beginning 11-19-14 the licensed nurses were in-serviced by Staff Development Coordinator regarding not leaving medications unattended. 4. Beginning on the week of 11-23-14 observational audits during medication administration will be conducted by the Registered Nurse Supervisor, Assistant Director of Nursing and/or Staff Development Coordinator to ensure medications are not left unattended or unsecured. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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DOVE HEALTH & REHAB OF COLLIERVILLE, LLC	490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017

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F 431	Continued From page 45 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 2 of 5 (Nurses #2 and 4) medication nurses did not leave medications unattended and out of their sight. The findings included: 1. Observations in Resident #120's room on 10/28/14 at 9:30 AM, revealed Nurse #2 placed prepared medications on the overbed table, walked to the hall to get a staff member to assist in pulling this resident up in the bed, assisted this resident up in the bed, and washed her hands in the bathroom. Nurse #2 left the medications unattended and out of sight as she left the room to get a staff member and while she was in the bathroom washing her hands. 2. Observations in Resident #63's room on 10/28/14 at 10:19 AM, revealed Nurse #4 placed medications on the overbed table, went into the bathroom to wash her hands, and left the medications on the overbed table unattended and out of sight. 3. During an interview in the staff development room on 10/29/14 at 4:35 PM, the Director of Nursing (DON) was asked about medications being left unattended. The DON stated, "They [medications] should not be left unattended."	F 431		

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F 441 F 441 SS=E	Continued From page 46 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F 441 1. CNA # 2 and CNA # 3 were in-serviced on 11-4-14 by the Staff Development Nurse in regards to hand hygiene, including emphasis on the washing of hands after each direct resident contact, after contact with inanimate objects and/or after the removal of gloves. Residents # 97 and # 55 were assessed by Director of Nursing on 10-31-14; no negative issues were identified. Nurse # 4 was in-serviced on 11-25-14 by the Director of Nursing in regards to hand hygiene during the administration of medications, with emphasis placed on the administration of eye ointments. Nurse # 5 was in-serviced on 11-25-14 by the Director of Nursing in regards to the utilization of gloves during insulin administration. Nurse # 6 was in-serviced on 11-26-14 by the Director of Nursing in regards to discarding dropped pills and performing hand hygiene during medication administration. Resident # 63 was assessed on 10-31-14 by Director of Nursing ; no negative issues were identified. Resident # 83 was assessed on 10-31-14 by Director of Nursing; no negative issues were identified. Resident # 51 was assessed on 10-31-14 by Director of Nursing; no negative issues were identified.	

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F 441	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained by 2 of 24 staff members (Certified Nursing Assistant (CNA) #2 and 3) during dining and by 3 of 5 (Nurses #4, 5 and 6) nurses during medication administration. The findings included: 1. Review of the facility's "Standard Precaution: Personal Protective Equipment" policy documented, "...GLOVES... 6. Wash hands immediately after removing gloves to avoid transfer of microorganisms to other resident or environments..." Review of the facility's "Standard Precaution: Hand Hygiene" policy documented, "...POLICY Assume every person is potentially infected or colonized with organisms that could be transmitted in the facility and apply the following infection control practices... GUIDELINES... If hands are not visibly soiled, alcohol-based hand rubs are preferred for hand hygiene: A. Before having direct contact with residents... C. After contact with resident's intact skin... E. After contact with inanimate objects... F. After removing gloves..." 2. Observations in Resident #97's room on 10/28/14 at 8:00 AM, revealed CNA #2 was assisting Resident #97 with the breakfast meal. CNA #2 got up and repositioned Resident #18, then returned and continued to assist Resident	F 441	2. An observational audit of the meal service was conducted on 11-3-14 by Staffing Development Coordinator to ensure hand hygiene was conducted per requirements; no negative issues were identified at that time. On 11-14-14 medication pass audit by observation was conducted by Staff Development Coordinator to ensure hand hygiene, the wearing of gloves during insulin administration, and discarding of dropped pills was performed per requirements; no negative issues were identified at that time. 3. Beginning on 11-23-14 the Staff Development Coordinator and the Assistant Director of Nursing in-serviced and performed hand hygiene skills checks with the nursing staff. Beginning on 11-20-14 the Staff Development Coordinator and the Assistant Director of Nursing in-serviced the licensed nurses in regards to hand hygiene during medication administration, the wearing of gloves during insulin administration, and the discarding of dropped pills. 4. Beginning on the week of 11-23-14 an observational audit of the meal service will be conducted by the Registered Nurse Supervisor, Assistant Director of Nursing, Director of Nursing, Staff Development Nurse, and/or the Central Supply Nurse to ensure hand hygiene is performed per requirements. The observational audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning on the week of 11-23-14 an observational medication pass audit will be conducted by the Staff Development Coordinator, Assistant Director of Nursing, and/or the Registered Nurse Supervisor to ensure hand hygiene, the wearing of gloves during insulin administration, and discarding of dropped pills is performed per requirements. The observational audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly there after.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 48 #97 without performing hand hygiene. During an interview in the staff development room on 10/29/14 at 7:35 AM, the Assistant Director of Nursing (ADON) was asked what she expects staff to do when assisting to feed a resident and repositioning another resident. The ADON stated, "Clean their hands and I prefer them to wash their hands." 3. Observations in Resident #55's room on 10/26/14 at 12:30 PM, CNA #3 placed a meal tray on the overbed table, applied gloves, assisted Resident #55 up in the bed, touching the resident and the bed, removed her gloves, without performing hand hygiene and continued to set up the tray. During an interview in the staff development room on 10/29/14 at 4:35 PM, the Director of Nursing (DON) was asked what should staff do after touching residents, in between glove use, and passing meal trays. The DON stated, "Should perform hand hygiene." 4. Observations on the low end of the 200 hall on 10/28/14 at 10:09 AM, revealed Nurse #4 prepared medications at the medication cart, knocked on Resident #63's door, went to the bathroom, touching door to room and the bathroom, obtained gloves, placed medications on the overbed table, applied the gloves without performing hand hygiene, applied eye ointment to Resident #63's lower lid, and removed her gloves, without performing hand hygiene. Nurse #4 went to the bathroom, obtained gloves and a tissue, applied the gloves, wiped Resident #63's eye with the tissue, removed the gloves, and then went to the bathroom and washed her hands.	F 441	The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11-28-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 49 During an interview in the staff development room on 10/29/14 at 4:35 PM, the DON was asked what should be done when using gloves. The DON stated, "Should perform hand hygiene." The DON was asked what should be done after touching residents, in between glove use, and administering medications. The DON stated, "Should perform hand hygiene." 5. Observations in Resident #83's room on 10/28/14 at 12:01 PM, revealed Nurse #5 administered insulin to Resident #83 without wearing gloves. Nurse #5 stated, "I messed up. I know what I did wrong. I did not wear gloves [while administering the insulin]." 6. Observations on the high end of the 100 hall on 10/29/14 at 9:15 AM, revealed Nurse #6 was preparing medications for Resident #51, dropped the resident's Ramipril the Coreg onto the medication cart, picked up these medications with her bare hands, and placed them in the medication cup. Nurse #6 applied gloves and broke a potassium pill in half, removed the gloves, and continued to prepare medications and administered these medications to Resident #51 without performing hand hygiene. During an interview in the staff development room on 10/29/14 at 4:35 PM, the DON was asked what should be done if pills are accidentally dropped onto the medication cart. The DON stated, "Should discard the pills and start over." The DON also confirmed the pills should not be touched bare handed.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 50 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on review of a job description, observation and interview, it was determined the facility failed to ensure the environment was clean, sanitary and free of offensive odors on 2 of 3 (200 and 300 hall) halls. The findings included: 1. Review of the the facility's housekeeper / aide job description documented, "...The Housekeeper/Aide Provides cleaning services within the facility to promote sanitary, comfortable and homelike environment for residents, staff and the public..." 2. Observations on the 200 hall on 10/26/14 at 9:15 AM and 3:29 PM, revealed a strong offensive odor in the hallway. 3. Observations on the 300 hall as exiting the elevator on 10/28/14 at 7:05 AM, revealed a very strong offensive odor that permeated the hallway. 4. During an interview while touring the 200 and 300 halls on 10/30/14 at 4:35 PM, the administrator was asked if he saw the housekeeping and cleanliness issues with the halls. The Administrator nodded his head in confirmation.	F 465	F 465 1. The 200 and 300 halls were cleaned on 10-31-14 by the Housekeeping Supervisor. 2. An audit was conducted on 3 of 3 halls by the Housekeeping Supervisor on 10-31-14 to ensure the environment was clean and odor free; issues were identified and addressed at that time 3. On 11-7-14, the Housekeeping Supervisor was in-serviced by the Administrator in regards to providing a clean, odor free environment. On 11-10-14 the Housekeeping Staff was in-serviced by housekeeping supervisor in regards to providing a clean, odor free environment. 4. Beginning on the week of 11-23-14 observational audits of the halls will be conducted by the Housekeeping Supervisor to ensure the environment is clean and odor free. The observational audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, 1 times a month for 1 month, then quarterly there after. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

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F 514 F 514 SS=D	Continued From page 51 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to completely and accurately document assessments of pressure ulcers or pain for 2 of 23 (Residents #128 and 173) sampled residents of the 44 residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #128 documented an admission date of 5/27/14 and a discharge date of 6/19/14 with diagnoses of Obstructive Chronic Bronchitis with Exacerbation, Chronic Airway Obstruction, Emphysema, Chronic Respiratory Failure, Dysphagia, Speech and Language Disorder and Tobacco Use Disorder. Review of an initial nursing summary and initial	F 514 F 514	F 514 1. Resident # 128 was discharged from the facility on 6-19-14. Resident # 173 was discharged from the facility on 11-3-14. 2. Beginning on 10-31-14 the Licensed Nurses, the Treatment Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Development Nurse conducted body audits on 99 of 99 residents; no negative issues were identified at that time. Beginning the week of 11-3-14 the Treatment Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Development Nurse conducted an audit via observation of 6 of 6 residents identified with pressure ulcers to ensure treatments were ordered by the physician, treatment orders were being administered per the physicians orders, and pressure ulcer assessments were being conducted weekly; no negative issues were identified at that time. Beginning on 11-25-14 the Assistant Director of Nursing conducted an audit of 52 of 52 resident's pain management flow records who are receiving pain medication to ensure the documentation of the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention was provided; issues identified were addressed at that time. 3. The Director of Nursing in-serviced the Treatment/licensed Nurses on 10-31-14 in regards to removal of dressings and skin assessment upon admission, conducting and documenting skin assessments, documentation of the correct dates on the Treatment Administration Records, and obtaining treatment orders from the physician.	

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F 514	Continued From page 52 care plan dated 5/27/14 documented, "SKIN CONDITION... SKIN INTEGRITY BREAKS: dressing [buttocks on diagram] dry and Intact... [LEFT BLANK]..." There was no skin assessment documented for the skin under the dressing of the buttock area. Review of a "Daily / Weekly / Monthly Body Audit and Hydration Report" dated May 2014 did not document any concerns of the skin. The nurses notes did not have documentation of a coccyx or sacral wound assessment for 5/27/14, 5/28/14, 5/29/14 or from 6/8/14 to 6/12/14. Review of wound and skin status reports documented the following: a. Identified on 5/27/14 Resident #128 had a pressure ulcer (not staged) to his sacrum. b. 5/28/14 - Resident #128 had a DTI to his coccyx. c. 6/8/14 - Resident #128 had a stage 2 pressure ulcer to his sacrum. d. 6/12/14 - Resident #128 had an unstageable wound to his sacrum. Review of skin inspection reports documented the following: a. "5/27/14 Skin Not Intact..." b. "5/28/14 Skin Intact..." c. "6/3/14 Skin Not Intact..." d. "6/10/14 Skin Not Intact..." e. "6/12/14 Skin Not Intact..." f. "6/17/14 Skin Not Intact..." g. "6/19/14 Skin Not Intact..." There was no complete assessment of the skin on the skin inspection reports.	F 514	The Staff Development Coordinator and Director of Nursing in-serviced the Licensed Nurses on 11-20-14 in regards to removal of dressings and skin assessment upon admission, conducting and documenting skin assessments, and obtaining treatment orders from the physician. Beginning the week of 11-23-14, the Staff Development Coordinator in-serviced the licensed nurses in regards to the documentation of the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention is provided on the resident's pain management flow record. 4. Beginning the week of 11-23-14 the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) will conduct audits of 3 resident's clinical records who have been newly admitted to the facility to ensure dressings were removed, if applicable, and a skin assessment was performed during the morning clinical meeting. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. Beginning the week of 11-23-14 the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Set Nurse, Activities Director, and Social Services) will conduct audits via observation of 3 residents identified as having pressure ulcers to ensure treatments were ordered by the physician, treatment orders are being administered per the physicians orders, and pressure ulcer assessments are being conducted weekly. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter.	

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F 514	Continued From page 53 Review of skin alert/body alert documentation revealed the following: a. 5/28/14 did not document any concerns of the skin on Resident #128's buttocks. b. 6/5/14 - Resident #128 had mild redness noted on his buttocks with a circle around the area. c. 6/11/14 - an area of concern on Resident #128's buttocks with a circle around the area. Review of Resident #128 wound care specialist evaluation forms documented the following: a. 5/29/14 - an unstageable (full thickness skin or tissue loss- depth unknown) deep tissue injury (localized area of discolored intact skin or blood filled blister) of the coccyx that resolved on 5/29/14 but had been present greater than 2 days. b. 6/12/14 - a stage 3 (full thickness skin loss subcutaneous fat may be visible) pressure wound of the sacrum with recommendations for wound care. c. 6/19/14 - an unstageable wound of the sacrum with recommendations for wound care. The facility was unable to provide documentation of any braden scale assessments completed. Review of the May 2014 Medication Administration Record (MAR)documented the wound treatment to cleanse sacral wound with wound cleanser, pat dry and apply hydrocolloid every 3 days was documented as being done on 5/8/14 through 5/11/14. Resident #128 was not admitted until 5/27/14. Review of the MAR dated 5/2014 (the DON stated this was actually a MAR for 6/2014, and was an inaccurate date) documented, "...cleanse sacral wound c [with] wound cleanser, pat dry,	F 514	Beginning the week of 11-23-14, the Licensed Nurses, Treatment Nurses, and/ or the Registered Nurse Supervisors, will conduct weekly skin assessments on the residents. The assessments will be reconciled against the resident census by the Assistant Director of Nursing and/or Registered Nurse Supervisor weekly. Beginning the week of 11-23-14, the Certified Nursing Assistants will conduct body audits on the residents three times weekly. The assessments will be reconciled against the resident census by the Assistant Director of Nursing, Treatment Nurse, and/or Registered Nurse Supervisor 3 times weekly. Beginning the week of 11-23-14 3 residents pain management flow records will be audited by the Registered Nurse Supervisor, Assistant Director of Nursing, and/or Staff Development Coordinator to ensure documentation reflects the resident's pain ratings, the method used to relieve the pain, and the reassessment of the pain rating after the intervention is provided. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 weeks, monthly for 1 month, then quarterly thereafter. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 11-28-14	11- 28-14

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F 514	Continued From page 54	F 514		

apply hydrocolloid q [every] 3 days until further order..." There were no treatments on the MAR for 5/27/14, 5/28/14 or 5/29/14.

Review of a wound healing progress report documented on 6/8/14, 6/12/14 and 6/19/14 that Resident #128 had an unstageable pressure ulcer of the sacrum.

Review of a Patient at High Risk (PAR) notes documented the following:
a. Week 1 dated 5/28/14 - "...Resident admitted c... PU [pressure ulcer]..."
b. Week 2 dated 6/5/14 - did not document any skin concerns.
c. Week 3 dated 6/11/14 - "...n.o [new order] to cleanse sacral opening c wound cleanser, pat dry, & [and] apply hydrocolloid q 3 days..."

Review of Resident #128's care plan documented the following:
a. 5/27/14 - "Problem... at risk for skin breakdown due to paraplegia... Approaches... Provide... pressure reducing surfaces on bed and chair..."
b. 6/12/14 - "...pressure ulcer: Sacrum... Approaches... weekly evaluation of wound healing... need a full skin evaluation weekly with bath/shower..."

During an interview in the staff development room on 10/28/14 at 4:25 PM, Treatment Nurse #1 stated, "I don't stage. The only time I measure the wound is when a resident comes in and I measure it. Then call [named wound care doctor] and she tells me what to put down for assessments." Treatment Nurse #1 stated, "The wound care doctor and the doctor does the measurements and I will write down the doctors's measurements and then place them in the

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F 514	Continued From page 55	F 514		

computer for the facility's documents. The wound care doctor keeps the documentation that she writes, the only information the facility has for assessments is the dictation from the wound care doctor once it is documented. The facility does not need the information and we do not keep a copy. The certified nursing assistants (CNAs) and nurses do skin assessments with the baths. The nurses also use the skin audit sheet, the nurse completes the form, and gives to the treatment nurse, and after 3 months, they are discarded." Treatment Nurse #1 was asked about Resident #128 pressure ulcer. Treatment Nurse #1 stated, "He had a DTI when he came in [5/27/14]." Treatment Nurse #1 was asked if the nurses notes had any wound documentation. Treatment Nurse #1 stated, "No ma'am. I don't see any."

During an interview in the staff development room on 10/28/14 at 5:00 PM, the Nurse Consultant was asked for a policy for skin assessments and wound care. The Nurse Consultant stated, "If a resident is deemed high risk they go through PAR this is our interdisciplinary team. We discuss patient's at risk, discuss patient's needs with the RD [Registered Dietician] and if needs equipment like a mattress. This is all we've got. We don't have a written protocol. I can tell you our process." The Nurse Consultant was asked how do the nurses know what to do if there is no policy. The Nurse Consultant stated, "We have a Braden Scale."

During an interview in the staff development room on 10/28/14 at 5:15 PM, the Nurse Consultant was asked if a resident is admitted with a dressing on his buttocks, what should the nurses do. The Nurse Consultant stated, "They [nurses] should have taken it [the dressing] off and looked

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F 514	Continued From page 56 at the skin." There was no documentation of a skin assessment provided when the resident was admitted. During an interview in the staff development room on 10/29/14 at 10:35 AM, the wound care doctor was asked where the information for the unstageable DTI of the coccyx came from on the dictated form. The wound care doctor stated, "I remember looking for it and it not being there." The wound care doctor was asked where she receives her information from if she is not in the building and the facility has a pressure ulcer. The wound care doctor stated, "If they are suspicious or they see something they will call me and I tell them what to put down. I will go back and look at it." The wound care doctor was asked about documentation on 6/12/14 where she had documented a stage 3 pressure wound, and what did she remember about this. The wound care doctor stated, "Called me on the weekend, it was [Named Treatment Nurse #2], told me how the wound looked, rounds would be later. The treatment nurse can not stage, it is described on the phone and that is what we go by." During an interview in the staff development room on 10/30/14 at 12:35 PM, the Director of Nursing (DON) was asked if the undated and unsigned Daily / Weekly / Monthly Body Audit and Hydration report was considered a body audit and skin assessment. The DON stated, "Yes." The DON was asked what the circled area might be. The DON stated, "An area of concern." The DON stated, "When the wound nurse comes in she should assess the wound." The DON stated, "Yes, should be documented what the wound looks like." The DON was asked about the assessment of wounds. The DON stated, "The	F 514		

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F 514	Continued From page 57 computer system we did have was difficult, the staff could not learn it or had difficulty learning it. The information [named Treatment Nurse #2] would put in did not match the information that [named wound care doctor] had on her notes, the stages never matched. 2. Review of the facility's pain management policy documented, "It is the policy of this facility to screen residents for pain and further assess if indicated for cause and severity of pain as well as what relieves the pain. All residents should receive treatment for pain relief as warranted and then monitored for effectiveness... A pain scale of 0- [to] 10 (0 = [means] no pain, 10 = worst pain) should be utilized for the adult resident..." Medical record review for Resident #173 documented an admission date of 10/16/14 with diagnoses of Congestive Heart Failure, Hypertension, Hyperlipidemia and Venous Ulcer of the Lower Left Leg and Left Inner Ankle. Review of the cognitive performance scale dated 10/16/14 documented the resident's decisions were consistent and reasonable, was able to make himself understood, had no short-term memory problems, and had no cognitive impairment. Review of the admission pain assessment dated 10/16/14 documented the resident's pain intensity in the past 5 days was rated between moderate and severe and what relieved the pain was Lortab 10/325 milligrams (mg). Review of Resident #173's pain management flow sheet part of the Medication Administration Sheet (MAR), for October 2014, documented no assessment of the resident's pain rating, the	F 514		

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F 514	Continued From page 58 method used to relieve the pain, or the reassessment of the pain rating after the intervention was provided. Review of a physician's order dated 10/16/14 documented the resident was to be given the pain medication, Lortab 10/325 mg (10 mg of hydrocodone and 325 mg of acetaminophen) one by mouth every 6 hours as the resident needed for pain control. The wound specialist's order dated 10/23/14 increased the frequency of the Lortab to every 4 hours as needed due to uncontrolled pain. During an interview in Resident #173's room on 10/27/14 at 8:40 AM, Resident #173 stated Lortab 10/325 relieves his pain. During an interview in the staff development room on 10/29/14 at 10:10 AM, the Director of Nursing (DON) was asked, if the nurses should be documenting the assessment and reassessment of a resident's pain. The DON stated, "Yes" and indicated the resident's pain documentation should be recorded on the "pain management flow sheet.	F 514		